GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
HEALTH CARE FACILITIES DIVISION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Investigation Date:
		7/24/2013
Home First	2501 18th Street, NE Washington, DC 20018	**Follow-up Dates(s):**

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
	SUMMARY OF THE COMPLAINT AND FINDINGS A complaint from the D.C. Long Term Care Ombudsman (DCLTCO) was filed with the Health Regulation and Licensing Administration on June 11, 2013. The complaint alleged that Home First failed to comply with the "Nursing Home and Community Residence Facility Residents' Protection Act in discharging Resident #1." Specifically, the DCLTCO alleged the following: 1. Allegation - The facility failed to provide the resident and his/her representative 21 day advance written notice. Finding – The resident was discharged due to an urgent medical care need that the facility could not provide; therefore, the 21 day time requirement for advance oral and written notice did not apply. Conclusion – Not Substantiated		Re: Allegation 2 CORRECTIVE ACTION PLAN/MEASURES & SYSTEMIC CHANGES TO BE IMPLEMENTED: On July 15, 2013, Home First received DOH's revised 2012 *Notice of Discharge, Transfer, Relocation and/or Transfer to Community Residential Facilities or Assisted Living* form. Effective immediately, the facility will utilize this form, which documents the specific location to which the resident is being discharged. In the event an emergency transfer is warranted again, the facility Administrator will sit with the resident and her/his representative(s) for the purpose of completing the form together so as to assure a clear understanding of the facility	August 7, 2013

Name of Inspector	Date Issued	Regine Clermont Facility Director/Designee	8-12-13 Date

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	2. Allegation – The specific location was not included on the discharge notice. Finding – The facility did not provide a specific location where the resident was being discharged. The notice reflected family, emergency room or medical facility. Conclusion – Substantiated 3. Allegation – The facility failed to provide the resident and the resident's representative with the rights to challenge the discharge. Finding – The facility failed to include with the discharge notice the resident's rights to challenge the discharge. Conclusion – Substantiated 4. Allegation – The facility failed to identify the name, address and telephone number of the person charged with the responsibility of supervising the discharge. Finding – The notice reflected the facility's administrator name, the facility's address and telephone number, but failed to indicate that the administrator was in charge of the discharge. Conclusion - Substantiated		and location to which the resident is to be discharged, the resident's rights to challenge the discharge and the name, address and telephone number of the person charged with the responsibility of supervising the discharge. Further, Home First has implemented a new *Discharge, Transfer and Relocation Policy* to prevent similar incidents in the future. This policy will be sent to DOH/HRA, HCFD separately. The Home First Administrator is currently planning in-service training for all resident care team members (the RN, Social Worker and Resident Care Coordinator), to occur between August 7th and August 31st, 2013. In the future, when discharge, transfer or relocation of a Home First resident to another facility is imminent, the Home First Administrator will alert the D.C. Long Term Care Ombudsman (DCLTCO) that such action impends. IDENTIFYING OTHER RESIDENTS WITH THE POTENTIAL TO BE IMPACTED BY THE SAME DEFICIENT PRACTICE: 1. The facility Administrator will closely monitor developing health issues of	By August 31, 2013 August 7,

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	The investigative findings were based on interviews and the review of records and correspondences. As a result of the investigative findings, deficiencies were cited as detailed below.		residents. 2. As the health status of a resident diminishes, the Administrator will meet with her/him and their representative(s) to inform them of their options for achieving appropriate medical care with a goal of providing as much advance notice of the potential for discharge, transfer or relocation to another facility as possible. 3. As stipulated in the CRF regulations, 3405.2, in regards to short term skilled care, the facility will arrange provisions and health care services and also allow the resident to remain in the facility up to 72 hours. 4. When it becomes necessary for the resident to be discharged, transferred or relocated, the Administrator will meet with the resident and her/his representative(s) to complete the *Notice of Discharge, Transfer, Relocation and/or Transfer to Community Residential Facilities or Assisted Living* form.	2013 August 7, 2013

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			HOW IMPLEMENTATION OF, AND COMPLIANCE WITH THE PLANNED CORRECTIVE ACTION WILL BE MONITORED: 1. The Chief Operating Officer of Seabury Resources for Aging will monitor implementation of, and compliance with the planned Corrective Action Plan. 2. The facility Administrator will report to the COO the progress of staff training regarding the new *Discharge, Transfer and Relocation Policy*. The COO will monitor Home First's staff's participation in the planned training to ensure that everyone understands the new policy by Sept. 1, 2013. 3. The facility Administrator will inform the COO about residents whose developing health issues may eventually place them at risk of discharge, transfer or relocation to another facility. The COO will be kept apprised of changes in such residents' health conditions. 4. As he is made aware of the worsening health conditions of particular	

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			residents, the COO will monitor adherence to the corrective actions proposed here. <u>Re: Allegation 3</u> The Plan of Correction and timeline documented previously for Allegation 2 will concurrently serve to prevent a similar incident as that substantiated in Allegation 3. <u>Re: Allegation 4</u> The Plan of Correction and timeline documented previously for Allegation 2 will concurrently serve to prevent a similar incident as that substantiated in Allegation 4.	
§44-1003.02	**<u>NOTICE TO RESIDENT AND RESIDENT'S REPRESENTATIVE</u>**			
§44-1003.02 (d)	**The CRF failed to include in the written notice a statement addressing resident's rights to challenge the facility's decision to discharge, transfer or relocate.**			
	Based on interviews with the facility's administrator and with the resident's representative (resident's daughter), and the			

	review of correspondences and records, the facility failed to provide proper notice of discharge for one (1) of one (1) resident being discharged. The findings include: On May 24, 2013 the facility issued an emergency discharge notice to resident #1's family. A review of the discharge notice, dated May 24, 2013, on July 8, 2013 failed to disclose or include the following: (1) The resident's rights to challenge the facility's decision to discharge Interview with the facility's administrator on July 24, 2013 revealed that the failure to include the right statement in the discharge notice was an oversight. (2) A hearing request form, together with a postage paid envelope preaddressed to the appropriate District official or agency; (3) The specific location to which the resident will be transferred; The facility did not provide a specific location where the resident was being discharged. The notice indicated that the resident was to be discharged to the family, emergency room or medical facility. Interview with the administrator revealed that the resident was to be discharged to the resident's			

	daughter's home and the emergency room and medical facility were only to be used as a resource if there was an urgent need for health services. Interviews with the resident's daughter on July 24, 2013 and, review of emails between the administrator and the daughter revealed that there was no communication, orally or written, prior to discharge, concerning placement options. According to the daughter, although there were several emails concerning the need to discharge her mother, the administrator failed to disclose alternative residences or options to address her mother's urgent needs. The daughter revealed that she was unaware of her rights and her mother's rights to a hearing to challenge the facility's decision to discharge. (4) The name, address, and telephone number of the person supervising the discharge. A review of the discharge notice, dated May 24, 2013, failed to include the name, address and telephone number of the person designated to provide discharge counseling. The notice reflected the facility's administrator's name, the facility's address and telephone number, but failed to indicate that the administrator was in charge of the discharge. Also, interview with the daughter on July 24, 2013, revealed			

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	that the facility did not offer discharge counseling.			